FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040535

Facility Name: HARMONY NURSING & REHAB. CENTER

Address: 3919 WEST FOSTER (Number) CHICAGO (City) 60625 (Zip Code)

County: COOK

Telephone Number: 773-588-9500 **Fax #** 773-588-9533

IDPA ID Number: 36-3969873-001

Date of Initial License for Current Owners: 12/14/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) NOSHIR DARUWALLA, C.P.A.

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,920	1
2		Skilled Pediatric (SNF/PED)			2
3	60	Intermediate (ICF)	60	21,960	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	180	TOTALS	180	65,880	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	26,808	8,706	4,615	40,129	8
9	SNF/PED					9
10	ICF	14,952	8,072	0	23,024	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,760	16,778	4,615	63,153	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.86%

D. How many bed-hold days during this year were paid by Public Aid? 1,858 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/14/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/25/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 39 and days of care provided 4,600

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2000 Fiscal Year: 12/31/2000

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTEI # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	280,611	99,979	6,760	387,350		387,350	2,723	390,073			1
2	Food Purchase		293,091		293,091	(51,130)	241,961	(983)	240,977			2
3	Housekeeping	310,748	44,761		355,509		355,509	8,905	364,414			3
4	Laundry	68,779	46,891		115,670		115,670		115,670			4
5	Heat and Other Utilities			107,109	107,109		107,109	2,832	109,941			5
6	Maintenance	51,108	16,503	139,302	206,913		206,913	(2,858)	204,055			6
7	Other (specify):*											7
8	**TOTAL General Services**	711,246	501,225	253,171	1,465,642	(51,130)	1,414,512	10,619	1,425,130			8
	B. Health Care and Programs											
9	Medical Director			18,750	18,750		18,750		18,750			9
10	Nursing and Medical Records	1,996,315	121,209	35,552	2,153,076		2,153,076	(169)	2,152,907			10
10a	Therapy	283,386		2,351	285,737		285,737		285,737			10a
11	Activities	84,857	8,709	2,224	95,790		95,790		95,790			11
12	Social Services	124,884		5,317	130,201		130,201		130,201			12
13	Nurse Aide Training			8,688	8,688		8,688		8,688			13
14	Program Transportation			1,107	1,107		1,107		1,107			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,489,442	129,918	73,989	2,693,349		2,693,349	(169)	2,693,180			16
	C. General Administration											
17	Administrative	47,876		182,000	229,876		229,876	27,758	257,634			17
18	Directors Fees											18
19	Professional Services			426,393	426,393		426,393	(275,975)	150,418			19
20	Dues, Fees, Subscriptions & Promotions			115,210	115,210		115,210	(44,430)	70,780			20
21	Clerical & General Office Expenses	168,024	4,800	131,636	304,460		304,460	94,539	398,999			21
22	Employee Benefits & Payroll Taxes			512,253	512,253	51,130	563,383		563,383			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,477	3,477		3,477	942	4,419			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			75,675	75,675		75,675	537	76,212			26
27	Other (specify):*							27,736	27,736			27
28	**TOTAL General Administration**	215,900	4,800	1,446,644	1,667,344	51,130	1,718,474	(168,893)	1,549,581			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,416,588	635,943	1,773,804	5,826,335		5,826,335	(158,443)	5,667,892			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

HARMONY NURSING & REHAB. CENTER
0040535
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	51,130	
2	FOOD		51,130

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER #0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			20,099	20,099		20,099	454,024	474,123			30
31	Amortization of Pre-Op. & Org.							10,944	10,944			31
32	Interest			224,843	224,843		224,843	581,852	806,695			32
33	Real Estate Taxes							324,822	324,822			33
34	Rent-Facility & Grounds			1,348,560	1,348,560		1,348,560	(1,348,560)				34
35	Rent-Equipment & Vehicles			25,331	25,331		25,331	(10,778)	14,553			35
36	Other (specify):*							45,735	45,735			36
37	**TOTAL Ownership**			1,618,833	1,618,833		1,618,833	58,039	1,676,872			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		158,583	230,472	389,055		389,055		389,055			39
40	Barber and Beauty Shops			15,470	15,470		15,470	(15,470)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,820	98,820		98,820		98,820			42
43	Other (specify):*	23,554			23,554		23,554	(23,554)				43
44	**TOTAL Special Cost Centers**	23,554	158,583	344,762	526,899		526,899	(39,024)	487,875			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,440,142	794,526	3,737,399	7,972,067		7,972,067	(139,428)	7,832,639			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(209)	2		4
5	Telephone, TV & Radio in Resident Rooms	(19)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	254,217	30		9
10	Interest and Other Investment Income	(14,343)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(774)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,798)	21		18
19	Entertainment				19
20	Contributions	(13,800)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,340)	21		24
25	Fund Raising, Advertising and Promotional	(32,018)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(85,341)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 68,575		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(208,003)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (208,003)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (139,428)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
HARMONY NURSING & REHAB. CENTER
ID# 0040535
Report Period Beginning: 01/01/00
Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Trust Fees	(900)	20	2
3	Marketing Salaries	(23,554)	43	3
4	Reimb. Auto Expense	(4,735)	35	4
5	Barber & Beauty Income	(15,470)	40	5
6	ILCLTC - Non-Allow. Portion	(284)	20	6
7	Profess.Fees - Bldg Part.	(8,702)	19	7
8	Auto Lease - Non-Allowable M. Hollander	(8,100)	35	8
9	Legal Fees - Non-Allowable	(16,044)	19	9
10	Legal Fees - Non-Allowable Prior Year	(1,906)	19	10
11	R & M Capitalized	(5,385)	6	11
12	Veterans Pharmacy	(169)	10	12
13	Misc. Income	(92)	21	13
14				14
15				15
16				16
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89				89
90	**Total**	(85,341)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			2,723									2,723	1
2	Food Purchase	(983)											(983)	2
3	Housekeeping			8,905									8,905	3
4	Laundry													4
5	Heat and Other Utilities	(19)		2,851									2,832	5
6	Maintenance	(5,385)		2,527									(2,858)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(6,387)		17,006									10,619	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(169)											(169)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(169)											(169)	16
	C. General Administration													
17	Administrative				27,758								27,758	17
18	Directors Fees													18
19	Professional Services	(26,652)	8,702	(197,294)	(60,731)								(275,975)	19
20	Fees, Subscriptions & Promotions	(47,002)		1,407	1,165								(44,430)	20
21	Clerical & General Office Expenses	(39,230)	400	125,093	8,276								94,539	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			897	45								942	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			537									537	26
27	Other (specify):*			22,909	4,827								27,736	27
28	**TOTAL General Administration**	(112,884)	9,102	(46,451)	(18,660)								(168,893)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(119,440)	9,102	(29,445)	(18,660)								(158,443)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	254,217	181,948	17,859									454,024	30
31	Amortization of Pre-Op. & Org.		10,779	165									10,944	31
32	Interest	(14,343)	583,369	12,826									581,852	32
33	Real Estate Taxes		319,642	5,180									324,822	33
34	Rent-Facility & Grounds		(1,348,560)										(1,348,560)	34
35	Rent-Equipment & Vehicles	(12,835)		2,057									(10,778)	35
36	Other (specify):*		45,735										45,735	36
37	**TOTAL Ownership**	227,039	(207,087)	38,087									58,039	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops	(15,470)											(15,470)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(23,554)											(23,554)	43
44	**TOTAL Special Cost Centers**	(39,024)											(39,024)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	68,575	(197,985)	8,642	(18,660)								(139,428)	45

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 1,348,560	KEIRO BLUILDING, LLC		$	$ (1,348,560)	1
2	V	32	INTEREST INCOME	91,249	KEIRO BLUILDING, LLC			(91,249)	2
3	V	21	OFFICE EXPENSE		KEIRO BLUILDING, LLC		400	400	3
4	V	19	PROFESSIONAL FEES		KEIRO BLUILDING, LLC		8,702	8,702	4
5	V	31	AMORTIZATION EXPENSE		KEIRO BLUILDING, LLC		10,779	10,779	5
6	V	33	REAL ESTATE TAXES		KEIRO BLUILDING, LLC		319,642	319,642	6
7	V	32	MORTGAGE INTEREST		KEIRO BLUILDING, LLC		674,618	674,618	7
8	V	36	MORTGAGE INSURANCE		KEIRO BLUILDING, LLC		45,735	45,735	8
9	V	30	DEPRECIATION EXPENSE		KEIRO BLUILDING, LLC		181,948	181,948	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,439,809			$ 1,241,824	$ * (197,985)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	ITEX COMPANY /A.K. CARE	100.00%	$ 2,723	$ 2,723	15
16	V	3	HOUSEKEEPING		ITEX COMPANY /A.K. CARE	100.00%	8,905	8,905	16
17	V	5	UTILITIES		ITEX COMPANY /A.K. CARE	100.00%	2,851	2,851	17
18	V	6	REPAIRS AND MAINT.		ITEX COMPANY /A.K. CARE	100.00%	2,527	2,527	18
19	V	19	PROFESSIONAL FEES		ITEX COMPANY /A.K. CARE	100.00%	4,706	4,706	19
20	V	20	FEES, SUBSCRIPTIONS		ITEX COMPANY /A.K. CARE	100.00%	1,407	1,407	20
21	V	21	CLERICAL AND GENERAL		ITEX COMPANY /A.K. CARE	100.00%	20,781	20,781	21
22	V	24	EDUCATION/SEMINARS		ITEX COMPANY /A.K. CARE	100.00%	897	897	22
23	V	26	INSURANCE		ITEX COMPANY /A.K. CARE	100.00%	537	537	23
24	V	27	EMPLOYEE BENEFITS		ITEX COMPANY /A.K. CARE	100.00%	375	375	24
25	V	30	DEPRECIATION		ITEX COMPANY /A.K. CARE	100.00%	17,859	17,859	25
26	V	31	AMORTIZATION		ITEX COMPANY /A.K. CARE	100.00%	165	165	26
27	V	32	INTEREST		ITEX COMPANY /A.K. CARE	100.00%	12,826	12,826	27
28	V	33	REAL ESTATE TAXES		ITEX COMPANY /A.K. CARE	100.00%	5,180	5,180	28
29	V	35	EQUIPMENT RENTAL		ITEX COMPANY /A.K. CARE	100.00%	2,057	2,057	29
30	V								30
31	V								31
32	V	21	CLERICAL SALARIES		ITEX COMPANY /A.K. CARE	100.00%	104,312	104,312	32
33	V	27	GEN ADMIN. - EMP. BEN.		ITEX COMPANY /A.K. CARE	100.00%	22,534	22,534	33
34	V								34
35	V	19	HOME OFFICE	202,000	ITEX COMPANY /A.K. CARE	100.00%		(202,000)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 202,000			$ 210,642	$ * 8,642	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	CAREPATH HEALTH NETWORK	100.00%	$ 27,758	$ 27,758	15
16	V	19	PROFESSIONAL FEES		CAREPATH HEALTH NETWORK		671	671	16
17	V	20	FEES, SUBSCRIPTIONS		CAREPATH HEALTH NETWORK		1,165	1,165	17
18	V	21	CLERICAL AND GENERAL		CAREPATH HEALTH NETWORK		8,276	8,276	18
19	V	24	SEMINARS		CAREPATH HEALTH NETWORK		45	45	19
20	V	27	GEN ADMIN.- EMP. BEN.		CAREPATH HEALTH NETWORK		4,827	4,827	20
21	V								21
22	V								22
23	V								23
24	V	19	HOME OFFICE	61,402	CAREPATH HEALTH NETWORK			(61,402)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 61,402			$ 42,742	$ * (18,660)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V							$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTI # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BERNARD HOLLANDER	OWNER	ADMN.	28.67%	SEE ATTACHED	2	3.08%		$		1
2	MARK HOLLANDER	OWNER	ADMN.	9.56%	SEE ATTACHED	30	50.00%	MGMT FEES	182,000	17-3	2
3	JACK RAJCHENBACH	OWNER	ADMN.	28.67%	SEE ATTACHED	2	3.08%				3
4	ROBERT HARTMAN	OWNER	ADMN.	28.67%	SEE ATTACHED	3.57	5.50%				4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 182,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ITEX COMPANY
Street Address: 6633 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 679-9141
Fax Number: (847) 679-1820

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	Available Bed Days	463,722	5	$ 19,169	$	65,880	$ 2,723	1
2	3	HOUSEKEEPING	Available Bed Days	463,722	5	62,684		65,880	8,905	2
3	5	UTILITIES	Available Bed Days	463,722	5	20,070		65,880	2,851	3
4	6	REPAIRS AND MAINT.	Available Bed Days	463,722	5	17,788		65,880	2,527	4
5	19	PROFESSIONAL FEES	Available Bed Days	463,722	5	33,128		65,880	4,706	5
6	20	FEES, SUBSCRIPTIONS	Available Bed Days	463,722	5	9,905		65,880	1,407	6
7	21	CLERICAL AND GENERAL	Available Bed Days	463,722	5	146,272		65,880	20,781	7
8	24	EDUCATION/SEMINARS	Available Bed Days	463,722	5	6,314		65,880	897	8
9	26	INSURANCE	Available Bed Days	463,722	5	3,777		65,880	537	9
10	27	EMPLOYEE BENEFITS	Available Bed Days	463,722	5	2,641		65,880	375	10
11	30	DEPRECIATION	Available Bed Days	463,722	5	125,704		65,880	17,859	11
12	31	AMORTIZATION	Available Bed Days	463,722	5	1,164		65,880	165	12
13	32	INTEREST	Available Bed Days	463,722	5	90,279		65,880	12,826	13
14	33	REAL ESTATE TAXES	Available Bed Days	463,722	5	36,464		65,880	5,180	14
15	35	EQUIPMENT RENTAL	Available Bed Days	463,722	5	14,476		65,880	2,057	15
16										16
17										17
18	21	CLERICAL SALARIES	Direct Allocation		5	735,869	735,869		104,312	18
19	27	GEN ADMIN. - EMP. BEN.	Direct Allocation		5	158,969			22,534	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,484,673	$ 735,869		$ 210,642	25

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPATH HEALTH NETWORK
Street Address: 6633 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (888) 707-6700
Fax Number: (847) 679-2150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	608,174	14	$ 274,940	$ 273,771	61,402	$ 27,758	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	608,174	14	6,646		61,402	671	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	608,174	14	11,535		61,402	1,165	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	608,174	14	81,974	63,989	61,402	8,276	4
5	24	SEMINARS	CARE PATH FEES	608,174	14	449		61,402	45	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	608,174	14	47,810		61,402	4,827	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 423,354	$ 337,760		$ 42,742	25

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number HARMONY NURSING & REHAB. CENTE # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HEARTLAND		X	MORTGAGE	$4,255.00		$	$ 9,115,363	4.1.33	9.80%	$ 674,618	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LASALLE BANK		X	LINE OF CREDIT	VARIOUS						944	6
7	AMERICAN NAT'L BANK		X	LINE OF CREDIT	VARIOUS	10.21.99			10.20.00	Various	94,925	7
8	LP STOCKHOLDERS	X		WORKING CAPITAL	VARIOUS			2,000,000		8.50%	45,879	8
9	TOTAL Facility Related				$4,255.00		$	$ 11,115,363			$ 816,366	9
	B. Non-Facility Related*											
10	Supplemental Schedule							7,839			(9,671)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$ 7,839			$ (9,671)	14
15	TOTALS (line 9+line14)						$	$ 11,123,202			$ 806,695	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	INTEREST EXPENSE - KEIRO	X					$	$			$ 82,210	1
2	INTEREST INCOME - KEIRO	X									(91,249)	2
3												3
4	ALLOC - ITEX	X									12,826	4
5												5
6	INTEREST INCOME		X								(14,343)	6
7												7
8	HILL-ROM NP		X					7,839			885	8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$ 7,839			$ (9,671)	21

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	340,306	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	327,106	2
3. Under or (over) accrual (line 2 minus line 1).	$	(13,200)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	338,022	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	324,822	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	273,943	8
	1996	256,331	9
	1997	318,447	10
	1998	324,101	11
	1999	321,925	12

R.E. Taxes Accrual 2000
$321,925 x 1.05 = $338,022
Allocation from ITEX - $5,180 included on line 2 above

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 64,216 B. General Construction Type: Exterior MASONARY Frame STEEL Number of Stories FOUR

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 377,250
2. Number of Years Over Which it is Being Amortized: 35
3. Current Period Amortization: 10,944
4. Dates Incurred: 1997

Nature of Costs: $10,779 Loan Fee - Keiro Bldg, LLC. + $165 Alloc. From Itex.
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1994	$ 600,000	1
2					2
3	TOTALS			$ 600,000	3

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	180		1994	1993	$ 7,019,409	$ 179,985	20	$ 350,971	$ 170,986	$ 2,112,931	4
5			Alloc.Keiro								5
6			Bldg Part.								6
7											7
8											8
	Improvement Type**										
9	Various			1994	11,156	418	20	586	168	3,692	9
10	MOTOROLA-TEL.SYSTEM			1996	8,539		20	427	427	2,064	10
11	UPGRADE PHONE SYS			1996	507	45	20	25	(20)	110	11
12	UPGRADE PHONE SYS			1996	507	45	20	25	(20)	110	12
13	ELEVATOR-DOORS			1997	1,750	45	20	88	43	301	13
14	LOCKS			1997	1,795	46	20	90	44	308	14
15	CHAIN LINK FENCE			1997	1,200	92	20	60	(32)	215	15
16	FANS ON ROOF			1997	3,867		20	193	193	805	16
17	WINDOWS			1998	546		20	27	27	59	17
18	RECIRCULATING PUMPS			1998	1,580		20	79	79	191	18
19	PLUMBING			1998	893		20	45	45	124	19
20	WALLPAPER			1998	1,923		20	96	96	280	20
21	30 AMP-208 VOLT CIRC			1998	1,000	26	20	50	24	133	21
22	DECORATING-PAINTING			1998	2,650		20	133	133	377	22
23	INGITER/CABLE			1998	620		20	31	31	67	23
24											24
25	PAGE 12-1 REP TOTALS				299,397	7,926		10,086	2,160	72,303	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33	PAGE 12C TOTALS				11,986			302	302	302	33
34	PAGE 12B TOTALS				5,385			134	134	134	34
35	PAGE 12A TOTALS				84,367	1,648		3,655	2,007	6,174	35
36	TOTAL (lines 4 thru 35)				$ 7,459,077	$ 190,276		$ 367,103	$ 176,827	$ 2,200,680	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ELEVATOR			1998	1,360	35	20	68	33	198	9
10	SMOKE DETECTOR			1998	590		20	30	30	70	10
11	FIRE DAMPERS			1998	1,089		20	54	54	113	11
12	LOCKSET			1998	660		20	33	33	69	12
13	VINYL			1999	522		20	26	26	41	13
14	DOORS			1999	1,947	50	20	97	47	186	14
15											15
16	AIR CONDITIONER			1999	2,208		20	110	110	156	16
17	AIR CONDITIONER			1999	1,104		20	55	55	83	17
18	FIRE ALARM RELAY BOA			1999	1,130		20	57	57	71	18
19	DOOR CLOSER			1999	630		20	32	32	61	19
20	WATER HEATER-16 GAL.			1999	129		20	6	6	8	20
21	CHAIN LINK FENCE			1999	1,879	48	20	94	46	180	21
22											22
23	TRANSFER SWITCHES			1999	37,000	949	20	1,850	901	3,238	23
24	OUTSIDE HYDRANTS			1999	2,455	63	20	123	60	185	24
25	FENCE			1999	1,389	36	20	69	33	115	25
26	FIRE DAMPERS			1999	2,200	56	20	110	54	193	26
27	FIRE DAMPERS			1999	8,775	225	20	439	214	805	27
28	EMERGENCY SYSTEM			2000	19,300	186	20	402	216	402	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 84,367	$ 1,648		$ 3,655	$ 2,007	$ 6,174	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	DOOR LOCK SAFETY			2000	1,174		20	29	29	29	10
11	WATER BOILER			2000	1,486		20	37	37	37	11
12	WALLPAPER VINYL			2000	904		20	23	23	23	12
13	WINDOW SYSTEM			2000	647		20	16	16	16	13
14	LIGHTING			2000	1,174		20	29	29	29	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 5,385	$		$ 134	$ 134	$ 134	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	MODEM HOOKUP			2000	1,737		20	44	44	44	9
10	BOILER DAMPER			2000	3,405		20	86	86	86	10
11	DSL CABLE WIRE			2000	1,035		20	26	26	26	11
12	RADIATOR			2000	2,001		20	50	50	50	12
13	THERMOSTAT			2000	2,548		20	64	64	64	13
14	COMMUNICATION			2000	1,260		20	32	32	32	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 11,986	$		$ 302	$ 302	$ 302	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993	Building	$ 227,884	$ 5,843	35	$ 6,511	$ 668	$ 49,374	4
5				(Alloc.Itex)							5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOC - ITEX			1993	28,674	1,005	20	1,434	429	11,048	9
10	ALLOC - ITEX			1994	15,402	634	20	770	136	4,837	10
11	ALLOC - ITEX			1995	2,625	217	20	131	(86)	682	11
12	ALLOC - ITEX			1996	149	13	20	7	(6)	37	12
13	ALLOC - ITEX			1997	4,428	114	20	221	107	775	13
14	ALLOC - ITEX			1999	492	13	20	25	12	49	14
15											15
16											16
17	ALLOC - KEIRO BUILDING LLC			1995	19,743	87	20	987	900	5,501	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 299,397	$ 7,926		$ 10,086	$ 2,160	$ 72,303	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,073,586	$ 17,471	$ 107,243	$ 89,772		$ 642,296	37
38	Current Year Purchases	43,274	10,806	(362)	(11,168)		3,550	38
39	Fully Depreciated Assets	10,833	1,353	139	(1,214)		10,833	39
40								40
41	TOTALS	$ 1,127,693	$ 29,630	$ 107,020	$ 77,390		$ 656,679	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 9,186,770	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 219,906	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 474,123	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 254,217	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,857,359	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

HARMONY NURSING & REHAB. CENTER
0040535
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
HARMONY NURSING & REHAB. CTR	89,239	6,187	8,826	2,639	34,371
ITEX A.K. CARE	77,205	9,408	7,703	(1,705)	37,566
KEIRO, LLC	907,142	1,876	90,714	88,838	570,359
TOTALS	1,073,586	17,471	107,243	89,772	642,296
LINE 29: CURRENT YEAR					
HARMONY NURSING & REHAB. CTR	40,213	10,194	(662)	(10,856)	3,250
ITEX A.K. CARE	3,061	612	300	(312)	300
KEIRO, LLC					
TOTALS	43,274	10,806	(362)	(11,168)	3,550
LINE 30: FULLY DEPRECIATED					
HARMONY NURSING & REHAB. CTR	6,276	1,353	139	(1,214)	6,276
ITEX A.K. CARE	4,557				4,557
KEIRO, LLC					
TOTALS	10,833	1,353	139	(1,214)	10,833
TOTALS (Should Tie to Totals on Page 13)					
HARMONY NURSING & REHAB. CTR	135,728	17,734	8,303	(9,431)	43,897
ITEX A.K. CARE	84,823	10,020	8,003	(2,017)	42,423
KEIRO, LLC	907,142	1,876	90,714	88,838	570,359
TOTALS	1,127,693	29,630	107,020	77,390	656,679

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: $ 7,540 Description: $1,119 Postage Meter, $3,424 Copier, $940 Bi-Pop mach. $2,057 Alloc. Itex
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	OLDSMOBILE	$ 529.00	$ 6,348	17
18	FACILITY	JAGUAR	#######	5,400	18
19	Page 5 Adjustment			(4,735)	19
20					20
21	TOTAL		$ #######	$ 7,013	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		245		245
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		8,443		8,443
9	TOTALS	$	$ 8,688	$	$ 8,688
10	SUM OF line 9, col. 1 and 2 (e)	$ 8,688			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 92,189	$		$ 92,189	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			25,352			25,352	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			112,931			112,931	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				106,356		106,356	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**						52,227		52,227	13
14	TOTAL			$		$ 230,472	$ 158,583		$ 389,055	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	28,319
2	Complex Medical Equip	12,267
3	Laboratory	9,606
4	Equipment Rental	2,035
5		
6		
7		
8		
9		
10		
		52,227

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 80,888	$ 117,078	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,751,441	2,751,441	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	450,148	450,148	5
6	Prepaid Insurance	96,107	133,974	6
7	Other Prepaid Expenses	319,036	319,036	7
8	Accounts Receivable (owners or related parties)	351,618	1,567,476	8
9	Other(specify): See supplemental schedule	308,688	911,274	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,357,926	$ 6,250,427	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		600,000	13
14	Buildings, at Historical Cost		7,022,809	14
15	Leasehold Improvements, at Historical Cos	91,800	91,800	15
16	Equipment, at Historical Cost	160,590	1,084,073	16
17	Accumulated Depreciation (book methods)	(112,572)	(2,120,960)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	2,351	344,571	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 142,169	$ 7,022,293	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,500,095	$ 13,272,720	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 814,913	$ 877,935	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	782,932	782,932	28
29	Short-Term Notes Payable	2,006,637	2,006,637	29
30	Accrued Salaries Payable	218,775	218,775	30
31	Accrued Taxes Payable (excluding real estate taxes)	26,598	26,598	31
32	Accrued Real Estate Taxes(Sch.IX-B)		338,022	32
33	Accrued Interest Payable	13,353	13,353	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	22,234	22,234	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	1,263,419	1,263,419	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,148,861	$ 5,549,905	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,172	1,172	39
40	Mortgage Payable		9,115,393	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,172	$ 9,116,565	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,150,033	$ 14,666,470	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (649,938)	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,500,095	$ #REF!	48

*(See instructions.)

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER **#** 0040535 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow		
BCBS CONTRACTUAL ALLOWANCE	11,922	
INTERCO. EXHANGE - K VACANT	277,686	
EMPLOYEE LOANS	19,080	
R.E. TAX & INS. ESCROW DEPOSITS		193,765
REPLACEMENT RESERVE		408,821
	308,688	602,586

OTHER CURRENT LIABILITIES:	Amount	Amount
INTERCO. EXCHANGE	1,215,858	
DUE TO ITEX MGMT	40,102	
DUE TO NUCARE/VISION	1,810	
BSBS - EXCHANGE	5,649	
	1,263,419	

OTHER NON CURRENT ASSETS:		
Construction In Progress		
SECURITY DEPOSITS	2,351	
LOAN FEES NET OF ACC.AMORT.		342,220
	2,351	342,220

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (300,600)	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (300,600)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	460,662	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(810,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (349,338)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (649,938)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	HARMONY NURSING & REHAB. CE #	0040535	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		(300,600)
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		(300,600)
Equity(Deficit) from Page 17 Col 1		(649,938)
Related Party		
Equity(Deficit)	-941797	
Income	197985	
		(743,812)
Combined Equity - End of Year		(1,393,750)

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,160,001	1
2	Discounts and Allowances for all Levels	(748,097)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,411,904	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	533,214	6
7	Oxygen	7,271	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 540,485	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	16,131	14
15	Telephone, Television and Radio	19	15
16	Rental of Facility Space		16
17	Sale of Drugs	195,486	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	67,809	19
20	Radiology and X-Ray		20
21	Other Medical Services	173,248	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 452,693	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	14,343	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 14,343	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	13,304	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,304	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,432,729	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,465,642	31
32	Health Care	2,693,349	32
33	General Administration	1,667,344	33
	B. Capital Expense		
34	Ownership	1,618,833	34
	C. Ancillary Expense		
35	Special Cost Centers	428,079	35
36	Provider Participation Fee	98,820	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,972,067	40
41	**Income before Income Taxes (line 30 minus line 40)****	460,662	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 460,662	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number HARMONY NURSING & REHAB. (# 0040535 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Telephone Commission Income	8,477
2	Auto Reimb. Income - Adjust out p. 5	4,735
3	Misc. Income - Adjust out p. 5	92
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	13,304

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,766	1,995	$ 58,425	$ 29.29	1
2	Assistant Director of Nursing	1,659	2,091	51,600	24.68	2
3	Registered Nurses	46,380	56,054	990,471	17.67	3
4	Licensed Practical Nurses	3,678	4,072	62,506	15.35	4
5	Nurse Aides & Orderlies	90,574	108,278	807,591	7.46	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	21,977	29,629	283,386	9.56	8
9	Activity Director	1,664	1,748	18,827	10.77	9
10	Activity Assistants	8,366	9,300	66,030	7.10	10
11	Social Service Workers	11,233	12,090	124,884	10.33	11
12	Dietician					12
13	Food Service Supervisor	2,091	2,131	29,542	13.86	13
14	Head Cook	3,135	3,386	39,947	11.80	14
15	Cook Helpers/Assistants	29,209	31,285	211,122	6.75	15
16	Dishwashers					16
17	Maintenance Workers	4,955	5,379	51,108	9.50	17
18	Housekeepers	41,546	44,785	310,748	6.94	18
19	Laundry	9,506	10,332	68,779	6.66	19
20	Administrator	2,080	2,350	47,876	20.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,891	14,306	168,024	11.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,997	2,257	25,722	11.40	31
32	Other Health Care(specify)					32
33	Other(specify)	836	1,108	23,554	21.26	33
34	TOTAL (lines 1 - 33)	295,543	342,576	$ 3,440,142 *	$ 10.04	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 6,760	1-3	35
36	Medical Director	Monthly	18,750	9-3	36
37	Medical Records Consultant	Monthly	4,752	10-3	37
38	Nurse Consultant	Monthly	29,000	10-3	38
39	Pharmacist Consultant	Monthly	1,800	10-3	39
40	Physical Therapy Consultant	17	1,088	10A-3	40
41	Occupational Therapy Consultant	20	1,263	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,224	11-3	44
45	Social Service Consultant	Monthly	5,317	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	37	$ 70,954		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	N/A	$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Marketing Salaries	836	1,108	$ 23,554	$ 21.26
	836	1,108	$ 23,554	$ 21.26

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Marc Sianghio	Administrator	0	$ 47,876
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 47,876

B. Administrative - Other

Description	Amount
MGMT FEES - MARK HOLLANDER	$ 182,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 182,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	Unemployment Consultant	$ 1,267
Power Software Development	Data Processing	12,452
AK Care	Home Office Costs	202,000
Carepath	Home Office Costs	61,402
See Attached Schedule	Legal Expenses	41,790
See Attached Schedule	Accounting Fees	102,682
Healthcare Horizon Mgmt	Management Consultants	4,800
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 426,393

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,624
Unemployment Compensation Insurance	31,102
FICA Taxes	260,945
Employee Health Insurance	124,068
Employee Meals	51,130
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	6,106
Misc. Employee Benefits	1,009
Saving Plan	42,747
Christmas Expense	4,652
TOTAL (agree to Schedule V, line 22, col.8)	$ 563,383

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	55,462
Health Care Worker Background Check	
(Indicate # of checks performed)	
Joint Commission Fees	2,308
Public Relations	32,018
Association Dues & Licenses&Inspection	2,183
Dues & Subscriptions	1,510
IC-LTC	6,345
Alloc. Itex & Carepath	2,572
Less: Public Relations Expense	(32,018)
Non-allowable advertising	(0)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 70,780

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,477
ALLOC. ITEX CO.	897
ALLOC. CAREPATH	45
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,419

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number HARMONY NURSING & REHAB. CENTER # 0040535 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICLTC - $2,308**

(3) Did the nursing home make political contributions or payments to a politica action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,633** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **98,820**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **51,130** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **209**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% In 1**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw